and ankle without irritation, but the final result was doubtful. The injection of a watery, and especially of an alcoholic solution, was always followed by a slight, transitory burning sensation. The 20 per cent. ointment (preferably made with lanolin) was used for an ulcer of the leg and for burns of the second degree. The granulations were of good character, but the healing process seemed to take longer than it did under the use of the gauze. This remedy is probably as valuable an antiseptic as iodoform, and is stronger than dermatol, aristol, iodol, pyoktanin, or europhen. It probably surpasses iodoform, because—1, it is odorless; 2, it dissolves easily; 3, it does not produce eczema; 4, it is not contra-indicated in kidney disease; 5, on account of its non-poisonous effects it can be applied to very extended surfaces. As a very small amount of the drug fulfils its purpose, the expense is small.—*New York Medical Journal*, 1893, vol. lvii., p. 438; *Notes on New Remedies*, 1893, No. 11, p. 177.

The following papers are worthy of notice:

"The Treatment of Malaria," by Dr. M. T. Schuiret, in the *Wiener medizinische Presse*, 1893, No. 13, p. 492, and No. 14, p. 535. A very careful review of the recent literature of quinine, phenocoll, methylene blue, helianthus annuus [sunflower], nitrates of soda or potash, alum, and hydrotherapy.

"Neurology and Therapeutics," by Dr. William R. Gowers, in the *British Medical Journal*, 1893, No. 1685, p. 781; No. 1686, p. 833; and the *Lancet*, 1893, No. 3633, p. 849.

MEDICINE.

UNDER THE CHARGE OF

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HEREDITARY ENLARGEMENT OF SPLEEN.

WILSON made a further communication to the Clinical Society of London (April, 1893) on some cases of hereditary enlargement of the spleen. The previous communication was in 1890. The possible malarial origin was finally abandoned. While, as regards the hereditary element, the cases were unique, they resembled in many important particulars some of the cases described under the term "splenic anæmia," "primitive splenomegaly," etc. All the cases in this series had occurred in adults, had run a more or less protracted course, and presented the following clinical characters: (1) Enlargement of the spleen without any corresponding enlargement of the glands; and (2) marked globular anæmia without leucocytosis. In some of the cases there had been fits of epistaxis, and in others febrile attacks, accompanied apparently by active destruction of the red blood-corpuscles. It was suggested that, for temporary purposes at least, the series might be usefully regarded as a single group, and that the name "chronic splenic cachexia" appeared the most suitable under which to describe cases possessing these characteristics.

RAPID PLEURAL EFFUSION.

WHITE (London) relates the following case (*Lancet*, 1893, No. 3630):

The patient had ordinary tubal nephritis together with mitral constriction and regurgitation. On December 16th, 36 ounces of fluid were withdrawn from the right chest. Next day there was excruciating pain in this region and 106 ounces were withdrawn (thirty hours after the first tapping). Seventy-eight hours later 120 ounces were removed from the same side. On this occasion there was again intense pain and dyspnœa and great œdema of the neck, probably due to the pressure on the superior vena cava. Thirty hours later 50 ounces were removed.

"It seems to me that the only possible explanation of this extraordinarily rapid accumulation of fluid is that the patient had thrombosis of her large azygos vein before it is joined by that from the left side. It is not against this view that we saw no enlarged superficial veins, for the most important anastomoses between the branches of the azygos veins of the two sides and the large azygos vein and the inferior vena cava are deep-seated in the abdomen, the thorax, and around the spine. Nor is it conclusively against this supposition that no evidence of thrombosis was found post-mortem, for the patient did not die till eight weeks afterward, by which time all signs of thrombosis might very well have disappeared. She had the clinical symptoms of thrombosis of her femoral vein only ten days before her death, and yet the vein was at the necropsy found to be patent. I have often observed that when patients have died no evidence has been forthcoming of thrombosis although all the signs of it have been present during life. It seems to me that no other explanation offers itself of this case, in which, supposing the fluid collected at a uniform rate, after the first tapping of the right chest that rate was three ounces and a half per hour, after the second one ounce and a half per hour, and after the third about one ounce and a half per hour. It is also quite exceptional for the distention of the chest with fluid to be so rapid as to cause acute pain, and it is no doubt comparable to the severe pain in the calf, felt in acute femoral thrombosis, and, like it, is probably due to the rapid stretching of the parts by the fluid; also it must be very rare for the pressure of the fluid in the superior vena cava to cause œdema of the neck."

VESICULAR ERUPTION ON THE PALATE: A SIGN OF INFLUENZA (?).

SHELLY draws attention (*Brit. Med. Journ.*, 1893, No. 1685) to a peculiar appearance of the soft palate. When examined in a good light it was found to be more or less completely studded with minute, translucent, lenticular elevations, somewhat resembling tiny, well-boiled grains of sago. The size was usually 0.5 mm., never exceeding 1 mm. in diameter.

"These vesicles were most abundant about the soft palate above the root of the uvula; but in some cases—and these were generally of the more severe type—they occupied a much larger area, being visible over the greater part of the roof of the mouth, but being always most marked and most abundant in the situation first mentioned. The patient was quite unconscious of and apparently unaffected by their existence.

"I was, of course, aware that the condition described is to be observed in cases other than those of influenza; nor do I yet venture to suggest that it is pathognomonic of that disease. No one can examine the throats of a large number of persons without occasionally observing the presence of these vesicles, to some extent at all events; but in connection with no other malady had I noticed them to be, not merely so frequently, but constantly, present, and this from the earliest period of the illness and throughout convalescence."

In the summer of 1891 abundant vesicles were noted in the case of every boy admitted to the Sick House at Haileybury College. Whenever, during that epidemic, vesicles were observed in boys who reported themselves on account of trivial injuries or other ailments, they were immediately sent to bed, and in one only out of forty did indubitable symptoms of influenza fail to develop within twenty hours. Of seventeen boys who—though complaining of malaise and exhibiting some pyrexia—did not present any abnormality of the palate, five only subsequently developed influenza.

These vesicles appear in all forms of the malady, but perhaps more conspicuously in the cases in which the respiratory passages are especially implicated. They persist throughout convalescence.

RAW PANCREAS IN THE TREATMENT OF DIABETES.

WHITE (London) records the following results (*Brit. Med. Journ.*, 1893, No. 1679). Two cases were submitted to treatment. Each patient was for the whole period of observation kept upon a diet consisting each day of twenty Soya-bean biscuits, two eggs, two ounces of butter, two almond biscuits, one fluidounce of milk, twelve ounces of cooked meat, greens, watercress, tea, and soda-water. The state of the patients and of the urine on this diet having been ascertained, each was given in addition, for his supper, about two ounces of raw fresh sheep's pancreas chopped fine and flavored with pepper and salt. When this was discontinued five minims of liquor pancreaticus were injected subcutaneously night and morning, the restricted diet being as before.

As regards the sugar, in one case it was distinctly less when raw pancreas was taken than it was before, and the same effect, but to a less degree, was associated with the injection of liquor pancreaticus subcutaneously. In the second case, neither of these methods had any effect in reducing the sugar.

Quantity of urine. No decided effect observed, nor was the specific gravity appreciably affected.

Urea. No effect was produced on this in Case 1. Possibly an increase was due to the treatment in Case 2.

General effects. The patients liked the raw pancreas. They did not lose weight on it; if anything, there was a slight improvement in their condition.

Disadvantages. In one case severe erythema with fever; in the other, sore-throat with rise of temperature.

White thinks it very doubtful whether any benefit is to be expected from this treatment of diabetes mellitus.

HEREDITARY (FRIEDREICH'S) ATAXIA.

SENATOR (*Berliner klin. Wochenschr.*, 1893, No. 21) has reported a case of hereditary (Friedreich's) ataxia in a male, nineteen years old. Awkwardness of gait had been observed during childhood, and had grown progressively worse. Intelligence was preserved; static ataxia was marked; the gait was unsteady; the knee-jerks were enfeebled and inconstant, even with reinforcement. Vertigo was complained of. Sensibility was normal, and there was no distinctive trophic change. There was a slight degree of horizontal nystagmus, but no other ocular symptom. The tongue occasionally presented slight fibrillary contractions. Speech was slow, drawling, and impeded, somewhat monotonous, but not scanning. The function of the sphincters was not deranged. A sister of the patient, thirty-two years old, had also presented similar symptoms from childhood. Senator does not agree with the view that ascribes the pathology of hereditary (Friedreich's) ataxia to combined sclerosis of the posterior and lateral columns of the spinal cord. He believes that the primary lesion is a congenital defect in the development of the cerebellum or of physiologically related parts in the medulla oblongata, and points out the close similarity between the symptoms of hereditary (Friedreich's) ataxia and those of cerebellar disease.

A CASE OF PULMONARY SYPHILIS.

JULLIEN (*Annales de Dermatologie et de Syphilographie*, tome iv., No. 4, p. 45) has reported the case of a woman, forty-six years old, who presented herself with ulceration and tumefaction of the right leg, that had existed for a year, and was painful and impeded the gait. The appearances were those typical of syphilis; besides, the tibia was found to be swollen. The woman had borne three healthy children by a first husband; her second husband was also dead, and had probably been syphilitic. The woman was greatly emaciated, extremely pale, and presented a cachectic appearance. For several months she had had constant fever, with vesperal exacerbations and night-sweats. The breathing was difficult, shallow, and rapid; cough was almost incessant. The expectoration was copious and muco-purulent. On physical examination, irregularly distributed areas of impaired pulmonary percussion-resonance were found, of greater extent and degree upon the left, with harsh breathing and fine and coarse moist and dry râles—in a word, the signs of infiltration and softening in various parts of the lungs. Careful and repeated examination of the sputum failed, however, to detect the presence of tubercle bacilli. Numerous animals inoculated with the sputum died of septic abscess formation, but none of tuberculosis. The woman was, besides, a pronounced dyspeptic, with marked gastrectasia. She was placed upon general tonic and constructive treatment, given potassium iodide by enema in milk, and subcutaneous injections of calomel. The improvement was so decided in the course of seven months that, notwithstanding admonition to the contrary, the woman withdrew from treatment. Her condition again became worse, but on resuming treatment pronounced improvement again took place. The results of physical examination now indicated retrogressive changes in the lungs. The woman, however, again became worse, anæmia and emaciation becoming marked, and hæmoptysis being so profuse as to threaten life. A course of injections, according to the method of Brown-Séquard, was now instituted, with results that exceeded anticipations.

THE BACTERIOLOGIC DIAGNOSIS OF CHOLERA.

THE following is the mode of procedure carried out at the Institute for Infectious Diseases at Berlin, in a bacteriologic study of a suspected case of cholera (*Zeitschrift f. Hygiene u. Infectionskrankh.*, 1893, Bd. xiv.; *Deutsche medicin. Wochenschrift*, 1893, No. 22, p. 523). Cover-glass preparations are first made (the flakes of mucus that are often present in the dejecta being selected) and stained with a dilute carbolized fuchsin solution. If comma bacilli be found, peptone cultures and gelatin plate-cultures are made. The peptone medium consists of a sterilized one per cent. watery solution of peptone and of sodium chloride, to which sufficient soda is added to impart a decided alkaline reaction. This is kept at a temperature of 37° C. If cholera bacilli are present in large number, a pure culture will be found on the surface of the peptone solution at the end of six hours; if present in smaller number, the culture will develop more slowly and there will be an admixture of other bacteria. It is best to look for the bacilli in from six to twelve hours after inoculation. If the peptone contain a certain proportion of nitrates, if the sulphuric acid employed be free from nitrous acid, and if the cultures be pure, the cholera-red (indol) reaction will take place. A good ten per cent. gelatin culture-medium is inoculated and kept at a temperature of 22° C. At the end of from fifteen to twenty hours characteristic appearances will have developed. If upon primary microscopic examination cholera bacilli have not been found, agar plates are cast in addition to the inoculation of the peptone solution and the gelatin plates. Six hours after the inoculation of the peptone solution curved bacilli are from time to time looked for; and as soon as found agar plates are cast. The material to be examined is preferably not mixed with liquefied agar; but the sterile agar is permitted to harden in covered dishes and placed for a few days in the thermostat to permit the expressed water to evaporate. The surface of the agar is then inoculated with the suspected material or from the peptone solution and kept at a temperature of 37° for eight or ten hours. If cholera bacilli be present they form colonies of light-yellow, transparent appearance. If few cholera bacilli have been found in the peptone solution and few or no colonies on the gelatin plates, suspicious or doubtful colonies upon the agar plates must be transferred to other agar plates, to peptone solution, and to gelatin plates, so that sufficient material may be obtained for the purposes of the indol reaction and of experiment upon animals. For this last purpose, cultures from the surface of agar plates are to be preferred. With a platinum loop, about 1.5 mg. of the culture are taken and mixed with 1 c.cm. of sterilized bouillon and injected into the peritoneal cavity of a guinea-pig. This is lethal for a pig weighing from 300 to 350 grammes. The peptone solution may also be employed for the detection of cholera bacilli in water. To about 100 c.cm. of the suspected water are added one per cent. each of peptone and sodium chloride and the mixture is kept at a temperature of 37°. In ten, fifteen, and twenty hours agar plates are to be inoculated with this solution. The resulting colonies are further cultivated upon peptone, glycerin, and agar, studied for the indol reaction, and injected into lower animals.

TUBERCULOSIS OF THE BUCCAL CAVITY, WITH PERFORATION INTO THE NARES AND MAXILLARY ANTRUM.

RETHI (*Wiener medicin. Presse*, Jahrg. xxxiv., No. 19, p. 721) has reported the case of a man thirty-one years old, without history of syphilis and without hereditary predisposition, who for eight years presented cough, with mucous expectoration, at times blood-streaked. In 1888 there appeared pain in the throat, particularly upon swallowing, together with hoarseness and cough. Some improvement in these symptoms took place, but they returned in the course of the following year. Examination now disclosed the evidences of a tuberculous process at the apex of the left lung and in the larynx. Matters grew gradually worse and in time the right lung also became tuberculous. The man's condition fluctuated for a couple of years, until, after the removal of a tooth and several roots, the opening left in the gum would not close and there resulted an ulcer, attended with considerable secretion. In the hope of effecting a cure other teeth were sacrificed and some fragments of bone were thrown off spontaneously. Little change took place in the process in the larynx, but that in the lungs steadily advanced. Histologic examination of a bit of tissue removed from the mouth in the neighborhood of the ulcerated area, disclosed the existence of a tuberculous process, round-celled infiltration, with epithelioid cells and giant cells, and in the midst of which a small number of tubercle bacilli were visible. The process advanced in spite of persistent treatment. Early in 1891, the left naris became occluded and soon afterward a communication was observed to have taken place between the mouth and the nares and the antrum of the upper jaw. Almost all of the upper teeth on the left side were gone, and the alveolar margin and the adjacent hard palate were destroyed. Difficulty in swallowing (fluids and solids entering the nares) and in speech rendered necessary the wearing of a plate of artificial teeth. Cauterization, curetting, applications of lactic acid, and other treatment proved of no avail. The glands behind the left sterno-mastoid muscle became enlarged and a cold abscess formed and had to be evacuated. The communication between the mouth and the nose finally extended from the left second molar tooth almost to the middle line, along the alveolar margin to the right second incisor and backward to the last molar, the roots of which were exposed. The under surface of the septum narium was exposed and the ulcerated, granular and purulent surface of the mucous membrane of the antrum was also to be seen. This condition of affairs continued until interrupted by the occurrence of death. It is an interesting question whether the tuberculous process in the mouth was secondary to the extraction of the tooth, or if such a process was the primary factor that led to the loosening of the tooth.

A REMARKABLE TRAUMATIC NEUROSIS.

PEL (*Berliner klinische Wochenschr.*, No. 24, p. 561) has reported the case of a man, twenty-seven years old, who fell a distance of two stories, possibly striking his head. Consciousness was lost and did not return for four hours, when severe headache appeared, referred particularly to the nape of the neck and the occipital region upon the left side. There was neither nausea nor vomiting, nor hemorrhage from the nose or ears, nor involuntary passage of urine or fecal matter. No external lesion could be discovered. The patient remained in bed for three days, complaining of left-sided occipital headache, vertigo, and drowsiness. Weakness of the right side of the body was also observed. Speech was not interfered with, but standing and walking were performed only with difficulty. On attempting to resume his occupation as a carpenter, after the lapse of four weeks, the man found himself unable to do so on account of headache, vertigo, and a sense of fatigue in the extremities, especially those of the right side. In the course of time vision became impaired and the other symptoms became aggravated, until, ten months after the accident, the patient was unable to stand or walk. In the recumbent posture, however, he had perfect control of the movements of the lower extremities, but as soon as an attempt was made to place him upon his feet the lower extremities would give way and the patient would fall unless supported. The knee-jerks were exaggerated. The face at the same time became red, and the skin covered with perspiration; the pulse increased in frequency, and the patient appeared as if exhausted. On examination a complete right-sided hemiparesis was found to exist. Common and special sensibility were normal, and there were no muscular or cutaneous trophic changes. The urine presented no abnormality. Upon laryngoscopic examination a polyp was found seated upon the anterior portion of the right vocal band, and which, upon phonation, became incarcerated between the two bands. A high degree of myopia existed, but there was neither choked disk, optic neuritis, limitation of the field of vision, nor disturbance of the color-sense. There was no neurotic or psychotic family history, and no personal history of alcoholic or venereal excesses. The diagnosis wavered for a time between functional derangement of the central nervous system—traumatic neurosis and organic disease of the cerebellum—tumor, cyst, abscess. It was determined to remove the polyp in the larynx, and immediately after the operation the man became aphonic. In the course of several weeks there developed right-sided hemianæsthesia, hemianalgesia, hemianosmia, hemiamblyopia, and bilateral loss of the sense of taste. A little later all doubt as to the diagnosis was removed by the occurrence of an hystero-epileptic attack, and some time later a second attack. In spite of assiduous treatment the condition of the man underwent little improvement. He was finally attacked with bilateral catarrhal pneumonia, to which he rather unexpectedly succumbed. A careful post-mortem examination failed to disclose any organic change to explain the symptoms present during life.